

EXHIBIT GG

to

**PLAINTIFFS' RESPONSE TO
DEFENDANTS' MOTION FOR
SUMMARY JUDGMENT**

Civil Action No.: 1:10-cv-00986-JFA

Reimbursement for Emergency Call Care



Aiken Regional

MEDICAL CENTERS

www.aikenregional.com

March 12, 2010

Dr. Margo Muniz
410 University Parkway
Suite 2300
Aiken, , SC 29801

Dear Dr. Muniz,

I am writing to inform you that the South Carolina Department of Health and Human Services, pending approval by the Centers of Medicare and Medicaid Services, has determined that Aiken Regional Medical Centers, Inc. qualifies for the SC Medicaid Disproportionate Share Hospital (DSH) Program for the Calendar year 2008.

Attached you will find a list of patients that qualified under the DSH program guidelines and according to our records, were under your care. The services you provided to these qualified patients during the indicated dates of services are eligible for payment of covered services at the SC Medicaid rates by the hospital. Please provide a copy of your FORM CMS-1500 or computer printout that shows detailed billing information for the listed patients. These copies should be sent to Aiken Regional Medical Centers, 302 University Parkway, Aiken, SC 29801, and **attention of Natalie Jarrett**. Submitting the claim forms by April 15, 2010 would help with timely processing for payment.

The payment for these claims will be made in May 2010. If you should require additional information or assistance, please do not hesitate to contact me at (803) 641-5696.

Sincerely,

Mark Tierney

Mark Tierney,
Chief Financial Officer

302 University Parkway • Aiken, SC 29801
803-641-5000

*Called Medical
Mark Tierney
7/23/2010
about payment
continued on
fair hearing*

www.aikenregional.com

Inpatient Private Pay		PATIENT #	ADM DATE	DOB	C PT		
PT NAME	ATN DR NAME		DSH DATE	SVC			
MCCAIN, SALLIE M		105024004	3/21/2008	2/20/1960 E			
TURNER, DEBORAH LAKI		105407969	1/31/2008	12/21/1978 E			
DE LA CRUZ, GABRIELA		105555825	2/26/2008	8/4/1985 E			
					MUNIZ MARGO	0	3/26/2008 GYN
					MUNIZ MARGO	0	2/3/2008 MAT
					MUNIZ MARGO	0	2/28/2008 MAT
						S	
						S	
						S	

Done
for this

Aug. 22. 2011 11:02AM

No. 4228 P. 4

PT NAME	PATIENT #	ADM DATE	DOB	ATN DR NAME	DSH DATE	SVC
VAZQUEZ, MARIO	105533087	2/20/2008	6/11/1963	MUNIZ LEOPOLDO	0	5/22/2008 OBS

AIKEN REGIONAL MEDICAL CENTER
MEDICAL AUDIT REPORT

PRIMARY PHYSICIAN - PHYSICIAN CONSULTATION AUDIT

INPATIENT UNINSURED ACCOUNTS

I. PATIENT NUMBER 105 400808
II. MEDICAL RECORD # 464
III. PATIENT NAME Campbell, Melissa
IV. DATES OF SERVICE 1/28 - 2/1/2008

A. PRIMARY PHYSICIAN & SPECIALTY Muniz, Margo
Obstetrical/Gynecology

CONSULTING PHYSICIAN: **COMPLETED CONSULT IN MEDICAL RECORD**

1. None
2. _____
3. _____
4. _____
5. _____
6. _____

DATE February 2010

June A. Metzger, R.N.
JUNE A. METZGER, R.N.
MEDICAL AUDITOR

AIKEN REGIONAL MEDICAL CENTER
MEDICAL AUDIT REPORT

PRIMARY PHYSICIAN - PHYSICIAN CONSULTATION AUDIT
INPATIENT UNINSURED ACCOUNTS

I. PATIENT NUMBER 105584122
II. MEDICAL RECORD # 60686
III. PATIENT NAME Lewis, Irene L.
IV. DATES OF SERVICE 6/13 - 6/21/2008
A. PRIMARY PHYSICIAN & SPECIALTY Muniz, Margo
Obstetrical gynecology

CONSULTING PHYSICIAN: **COMPLETED CONSULT IN MEDICAL RECORD**

1. None
2. _____
3. _____
4. _____
5. _____
6. _____

DATE February 2010

June A. Metz, R.N.
JUNE A. METZE, R.N.
MEDICAL AUDITOR

AIKEN REGIONAL MEDICAL CENTER
MEDICAL AUDIT REPORT

PRIMARY PHYSICIAN - PHYSICIAN CONSULTATION AUDIT

INPATIENT UNINSURED ACCOUNTS

I. PATIENT NUMBER 103680716
II. MEDICAL RECORD # 140399
III. PATIENT NAME McDonnell, Jessica
IV. DATES OF SERVICE 12/12/2006

A. PRIMARY PHYSICIAN & SPECIALTY Muniz, Margo
Obstetrics/gynecology

CONSULTING PHYSICIAN:

COMPLETED CONSULT IN MEDICAL RECORD

1. None
2. _____
3. _____
4. _____
5. _____
6. _____

DATE February 2010

June A. Metz, R.N.
JUNE A. METZE, R.N.
MEDICAL AUDITOR

AIKEN REGIONAL MEDICAL CENTER
MEDICAL AUDIT REPORT

PRIMARY PHYSICIAN - PHYSICIAN CONSULTATION AUDIT

INPATIENT UNINSURED ACCOUNTS

I. PATIENT NUMBER 105925275
II. MEDICAL RECORD # 62544
III. PATIENT NAME Osman, Belinda H.
IV. DATES OF SERVICE 5/28 - 6/1/2008

A. PRIMARY PHYSICIAN & SPECIALTY Muniz, Margo
Obstetrics / Gynecologist

CONSULTING PHYSICIAN:

COMPLETED CONSULT IN MEDICAL RECORD

1. Muniz, Margo (Obstetrics/Gynecology) yes
(pt. Admitted to Dr. Hagan who
requested Consult with Margo Muniz, M.D.
She saw the pt & then apparently
assumed in-pt care. Discharge Summary
written by Dr. Margo Muniz

DATE February 2010

June A. Metz, R.N.
JUNE A. METZE, R.N.
MEDICAL AUDITOR

AIKEN REGIONAL MEDICAL CENTER
MEDICAL AUDIT REPORT

PRIMARY PHYSICIAN - PHYSICIAN CONSULTATION AUDIT

INPATIENT UNINSURED ACCOUNTS

I. PATIENT NUMBER 105344766
II. MEDICAL RECORD # 233598
III. PATIENT NAME Slavin, Jane E.
IV. DATES OF SERVICE 2/11 - 2/14/2008

A. PRIMARY PHYSICIAN & SPECIALTY Muniz, Margo
Obstet recs / gynecology

CONSULTING PHYSICIAN: **COMPLETED CONSULT IN MEDICAL RECORD**

1. Barley, John (Family Medicine) yes
2. _____
3. _____
4. _____
5. _____
6. _____

DATE February 2010

June A. Metz, R.N.
JUNE A. METZE, R.N.
MEDICAL AUDITOR

Laura,

Here are our bills for the staff call patients in 2008. Our charges were around 13000.00. These will of course be adjusted down like with insurance contracts but this is what we charged for these services.

Jewel had trouble getting Mark Tierney to call her back regarding these past due invoices. When he called Jewel and Maria were in the room and he told them that Margo's payment was contingent on the outcome of her "fair hearing". This was on 7/28/2010.

Thanks,



Marla

Payment is contingent
on whether she is on
staff or not from
fair hearing
Talked to
Mark Tierney on
7/28/2010

MetLife



32587

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

AIKEN REGIONAL MEDICAL C
 302 UNIVERSITY PARKWAY

AIKEN SC 298021117

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 476554444																																																																							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) SLAVIN JANE		3. PATIENT'S BIRTH DATE MM DD YY 12 03 1947 SEX <input checked="" type="checkbox"/> F <input type="checkbox"/> M																																																																							
4. INSURED'S NAME (Last Name, First Name, Middle Initial) SLAVIN JANE		5. INSURED'S ADDRESS (No., Street) 905 GEORGETOWN DRIVE																																																																							
6. PATIENT'S ADDRESS (No., Street) 905 GEORGETOWN DRIVE		7. INSURED'S ADDRESS (No., Street) 905 GEORGETOWN DRIVE																																																																							
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input checked="" type="checkbox"/>		9. CITY NORTH AUGUSTA																																																																							
10. STATE SC		11. CITY NORTH AUGUSTA																																																																							
12. ZIP CODE 29841		13. TELEPHONE (Include Area Code) (803) 278-2361																																																																							
14. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		15. INSURED'S POLICY GROUP OR FECA NUMBER																																																																							
16. OTHER INSURED'S POLICY OR GROUP NUMBER		17. INSURED'S DATE OF BIRTH MM DD YY 12 03 1947 SEX <input checked="" type="checkbox"/> F <input type="checkbox"/> M																																																																							
18. OTHER INSURED'S DATE OF BIRTH MM DD YY		19. EMPLOYER'S NAME OR SCHOOL NAME																																																																							
20. EMPLOYER'S NAME OR SCHOOL NAME		21. INSURANCE PLAN NAME OR PROGRAM NAME ARMC																																																																							
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24. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED SIGNATURE ON FILE DATE 3/19/2010																																																																									
25. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED SIGNATURE ON FILE																																																																									
26. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		27. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY																																																																							
28. NAME OF REFERRING PROVIDER OR OTHER SOURCE		29. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 02 11 2008 TO MM DD YY																																																																							
30. RESERVED FOR LOCAL USE		31. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES																																																																							
32. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)		33. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																																																							
34. 1. 183 8		35. PRIOR AUTHORIZATION NUMBER																																																																							
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36. FEDERAL TAX I.D. NUMBER 204598150		37. PATIENT'S ACCOUNT NO. 32587P18742																																																																							
38. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) MARGO J HEIN MUNIZ MD		39. SERVICE FACILITY LOCATION INFORMATION AIKEN REGIONAL MEDICAL CENTER 302 UNIVERSITY PKWY AIKEN SC 29801																																																																							
40. TOTAL CHARGE \$ 6984 00		41. AMOUNT PAID \$ 6984 00																																																																							
42. BILLING PROVIDER INFO & PH. # FMC 410 UNIVERSITY PKWY AIKEN SC 29801		43. BALANCE DUE \$ 6984 00																																																																							

CARRIER
 PATIENT AND INSURED INFORMATION
 PHYSICIAN OR SUPPLIER INFORMATION

AIKEN SC 298021117

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466
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FICA

PHYSICIAN OR SUPPLIER INFORMATION[illegible]

AIKEN REGIONAL MEDICAL C
302 UNIVERSITY PARKWAY

AIKEN SC 298021117

HEALTH INSURANCE CLAIM FORM
 APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE MEDICAID TRICARE CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)		1a. INSURED'S I.D. NUMBER 249232373	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MCCAIN SALLIE M		4. INSURED'S NAME (Last Name, First Name, Middle Initial) MCCAIN SALLIE M	
3. PATIENT'S BIRTH DATE MM DD YY 02 20 1960		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 65 KNIGHT LANE		7. INSURED'S ADDRESS (No., Street) 65 KNIGHT LANE	
CITY TRENTON		CITY TRENTON	
STATE SC		STATE SC	
ZIP CODE 29847		ZIP CODE 29847	
TELEPHONE (Include Area Code) (803) 663-7749		TELEPHONE (Include Area Code) (803) 663-7749	
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		11. INSURED'S POLICY GROUP OR FECA NUMBER	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		a. INSURED'S DATE OF BIRTH MM DD YY 02 20 1960 M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
c. EMPLOYER'S NAME OR SCHOOL NAME		b. EMPLOYER'S NAME OR SCHOOL NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME ARMC	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. SIGNATURE ON FILE DATE 3/19/2010		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 620 0 2. 614 6 3. 617 0		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 03 21 08 03 21 08 21		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER 58661 123 1734 00 1		23. PRIOR AUTHORIZATION NUMBER	
F. \$ CHARGES G. DAYS OR UNITS H. REPT PER I. ID. QUAL. J. RENDERING PROVIDER ID. # 1457348526			
25. FEDERAL TAX I.D. NUMBER 204598150		26. PATIENT'S ACCOUNT NO. 32581F19135	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 1734 00	
29. AMOUNT PAID \$ 1734 00		30. BALANCE DUE \$ 1734 00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) ARGO J HEIN MUNIZ MD 3/19/2010		32. SERVICE FACILITY LOCATION INFORMATION AIKEN REGIONAL MEDICAL CENTER 302 UNIVERSITY PKWY AIKEN SC 29801	
33. BILLING PROVIDER INFO & PH. # PMC 410 UNIVERSITY PKWY AIKEN SC 29801			

CARRIER
 PATIENT AND INSURED INFORMATION
 PHYSICIAN OR SUPPLIER INFORMATION

32583

AIKEN REGIONAL MEDICAL C
302 UNIVERSITY PARKWAY

AIKEN SC 298021117

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 248338462	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) OSMAN BELINDA D		4. INSURED'S NAME (Last Name, First Name, Middle Initial) OSMAN BELINDA D	
3. PATIENT'S BIRTH DATE MM DD YY 03 23 1972 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. INSURED'S ADDRESS (No., Street) 283 HERBERT LANE	
5. PATIENT'S ADDRESS (No., Street) 283 HERBERT LANE		CITY WILLISTON STATE SC	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		ZIP CODE 29853 TELEPHONE (Include Area Code) (803) 266-5135	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input checked="" type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER	
Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		a. INSURED'S DATE OF BIRTH MM DD YY 03 23 1972 SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		b. EMPLOYER'S NAME OR SCHOOL NAME ARMC	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		c. INSURANCE PLAN NAME OR PROGRAM NAME	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete Item 9 a-d.	
c. EMPLOYER'S NAME OR SCHOOL NAME		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.			
SIGNATURE ON FILE DATE 3/19/2010			
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY			
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY			
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI 17b. NPI			
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19. RESERVED FOR LOCAL USE			
20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 789 00 3. 787 91			
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.			
23. PRIOR AUTHORIZATION NUMBER			
24. A. DATE(S) OF SERVICE B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EXPT PER I. ID. QUAL J. RENDERING PROVIDER ID. #			
1. 05 26 08 05 26 08 23 99254 123 242 00 1 NPI 1457348526			
2. NPI			
3. NPI			
4. NPI			
5. NPI			
6. NPI			
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see book) 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE			
204598150 <input type="checkbox"/> <input checked="" type="checkbox"/> 32583P21161 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO \$ 242 00 \$ 242 00			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS) (I certify that the statements on the reverse apply to this bill and are made a part thereof.) MARGO J HEIN MUNIZ MD			
32. SERVICE FACILITY LOCATION INFORMATION AIKEN REGIONAL MEDICAL CENTER 302 UNIVERSITY PKWY AIKEN SC 29801			
33. BILLING PROVIDER INFO & PH. # (803) 649-6366			

32584

AIKEN REGIONAL MEDICAL C.
 302 UNIVERSITY PARKWAY

AIKEN SC 298021117

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 248338462	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) OSMAN BELINDA D		4. INSURED'S NAME (Last Name, First Name, Middle Initial) OSMAN BELINDA D	
3. PATIENT'S BIRTH DATE MM DD YY 03 23 1972 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. INSURED'S ADDRESS (No., Street) 283 HERBERT LANE	
5. PATIENT'S ADDRESS (No., Street) 283 HERBERT LANE		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input checked="" type="checkbox"/>	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		9. CITY WILLISTON STATE SC	
7. CITY WILLISTON STATE SC		10. ZIP CODE 29853	
8. TELEPHONE (Include Area Code) (803) 266-5135		11. TELEPHONE (Include Area Code) (803) 266-5135	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		12. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX <input type="checkbox"/> M <input type="checkbox"/> F		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED SIGNATURE ON FILE DATE 3/19/2010		11. INSURED'S POLICY GROUP OR FECA NUMBER	
13. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.		12. INSURED'S DATE OF BIRTH MM DD YY 03 23 1972 SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		13. EMPLOYER'S NAME OR SCHOOL NAME	
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY		c. INSURANCE PLAN NAME OR PROGRAM NAME ARMC	
16. NAME OF REFERRING PROVIDER OR OTHER SOURCE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
17a. NPI		14. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED SIGNATURE ON FILE	
17b. NPI		15. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
18. RESERVED FOR LOCAL USE		16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line) 1. 789 00 3. 617 0		17. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	
2. 569 3 4. 568 0		18. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
24. A. DATE(S) OF SERVICE To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS UNITS H. REFERRAL I. ID. QUAL. J. RENDERING PROVIDER ID. #		19. PRIOR AUTHORIZATION NUMBER	
1. 05 27 08 05 27 08 21 99233 1234 150 00 1		20. F. \$ CHARGES G. DAYS UNITS H. REFERRAL I. ID. QUAL. J. RENDERING PROVIDER ID. #	
2. 05 27 08 05 27 08 21 99233 1234 150 00 1		21. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
3. 05 27 08 05 27 08 21 99233 1234 150 00 1		22. PRIOR AUTHORIZATION NUMBER	
4. 05 27 08 05 27 08 21 99233 1234 150 00 1		23. F. \$ CHARGES G. DAYS UNITS H. REFERRAL I. ID. QUAL. J. RENDERING PROVIDER ID. #	
5. 05 27 08 05 27 08 21 99233 1234 150 00 1		24. F. \$ CHARGES G. DAYS UNITS H. REFERRAL I. ID. QUAL. J. RENDERING PROVIDER ID. #	
6. 05 27 08 05 27 08 21 99233 1234 150 00 1		25. F. \$ CHARGES G. DAYS UNITS H. REFERRAL I. ID. QUAL. J. RENDERING PROVIDER ID. #	
25. FEDERAL TAX I.D. NUMBER SSN EIN 204598150 <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 32584P21161	
26. PATIENT'S ACCOUNT NO. 32584P21161		27. ACCEPT ASSIGNMENT? (For govt. claims, see book) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
27. ACCEPT ASSIGNMENT? (For govt. claims, see book) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 150.00	
28. TOTAL CHARGE \$ 150.00		29. AMOUNT PAID \$ 150.00	
29. AMOUNT PAID \$ 150.00		30. BALANCE DUE \$ 150.00	
30. BALANCE DUE \$ 150.00		31. BILLING PROVIDER INFO & PH. # (803) 649-6366	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) MARGO J HEIN MUNIZ MD		32. SERVICE FACILITY LOCATION INFORMATION AIKEN REGIONAL MEDICAL CENTER 302 UNIVERSITY PKWY AIKEN SC 29801	

Aug. 22. 2011 11:07AM

No. 4228 P. 16

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AIKEN REGIONAL MEDICAL C
302 UNIVERSITY PARKWAY

AIKEN SC 298021117

(1500)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 248338462	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) OSMAN BELINDA D		4. INSURED'S NAME (Last Name, First Name, Middle Initial) OSMAN BELINDA D	
3. PATIENT'S BIRTH DATE MM DD YY 03 23 1972 M <input type="checkbox"/> F <input checked="" type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) 283 HERBERT LANE	
5. PATIENT'S ADDRESS (No., Street) 283 HERBERT LANE		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY WILLISTON STATE SC		CITY WILLISTON STATE SC	
ZIP CODE 29853 TELEPHONE (Include Area Code) (803) 266-5135		ZIP CODE 29853 TELEPHONE (Include Area Code) (803) 266-5135	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input checked="" type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER	
Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		a. INSURED'S DATE OF BIRTH MM DD YY 03 23 1972 M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		b. EMPLOYER'S NAME OR SCHOOL NAME ARMC	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		c. INSURANCE PLAN NAME OR PROGRAM NAME ARMC	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.	
c. EMPLOYER'S NAME OR SCHOOL NAME		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10. RESERVED FOR LOCAL USE	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED SIGNATURE ON FILE DATE 3/19/2010			
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate items 1, 2, 3 or 4 to item 24E by line) 1. 789 00 3. 617 9 2. 569 3 4. 568 0		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		23. PRIOR AUTHORIZATION NUMBER	
B. PLACE OF SERVICE		F. \$ CHARGES	
C. EMG		G. DAYS UNITS	
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) ORTHOPOD MODIFIER		H. EXPT PM	
E. DIAGNOSIS POINTER		I. ID. QUAL	
1. 05 28 08 05 28 08 21 99233 1234 150 00 1		J. RENDERING PROVIDER ID. # 1457348526	
2. 05 28 08 05 28 08 21 99233 1234 150 00 1		NPI	
3. 05 28 08 05 28 08 21 99233 1234 150 00 1		NPI	
4. 05 28 08 05 28 08 21 99233 1234 150 00 1		NPI	
5. 05 28 08 05 28 08 21 99233 1234 150 00 1		NPI	
6. 05 28 08 05 28 08 21 99233 1234 150 00 1		NPI	
25. FEDERAL TAX I.D. NUMBER 204598150 SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 32585921161	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 150.00	
29. AMOUNT PAID \$		30. BALANCE DUE \$ 150.00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) MARGO J HEIN MUNIZ MD 3/19/2010		32. SERVICE FACILITY LOCATION INFORMATION AIKEN REGIONAL MEDICAL CENTER 302 UNIVERSITY PKWY AIKEN SC 29801	
33. BILLING PROVIDER INFO & PH. # (803) 649-6366 PMC 410 UNIVERSITY PKWY AIKEN SC 29801			

32586

AIKEN REGIONAL MEDICAL C
302 UNIVERSITY PARKWAY

AIKEN SC 298021117

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 248338462	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) OSMAN BELINDA D		4. INSURED'S NAME (Last Name, First Name, Middle Initial) OSMAN BELINDA D	
3. PATIENT'S BIRTH DATE MM DD YY 03 23 1972 SEX <input checked="" type="checkbox"/> F <input type="checkbox"/> M		7. INSURED'S ADDRESS (No., Street) 283 HERBERT LANE	
5. PATIENT'S ADDRESS (No., Street) 283 HERBERT LANE		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY WILLISTON STATE SC		CITY WILLISTON STATE SC	
ZIP CODE 29853 TELEPHONE (Include Area Code) (803) 266-5135		ZIP CODE 29853 TELEPHONE (Include Area Code) (803) 266-5135	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX <input type="checkbox"/> M <input type="checkbox"/> F		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED SIGNATURE ON FILE DATE 3/19/2010		11. INSURED'S POLICY GROUP OR FECA NUMBER ARMC	
14. DATE OF CURRENT: MM DD YY 03 23 2010		13. INSURED'S DATE OF BIRTH MM DD YY 03 23 1972 SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY		b. EMPLOYER'S NAME OR SCHOOL NAME	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		c. INSURANCE PLAN NAME OR PROGRAM NAME	
19. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 8 a-d.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 789 00 3. 236 3		18. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED SIGNATURE ON FILE	
2. 614 1 4. 569 3		19. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
1. 05 29 08 05 29 08 21 58661 1234		17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
2.		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	
3.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
4.		23. PRIOR AUTHORIZATION NUMBER	
5.		F. \$ CHARGES G. DAYS OR UNITS H. EPSON Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #	
6.		1. 2040 00 1 1457348526	
25. FEDERAL TAX I.D. NUMBER 204598150 SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 32586F21161	
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 2040 00	
29. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) MARGO J HEIN MUNIZ MD		29. AMOUNT PAID \$ 2040 00	
30. SERVICE FACILITY LOCATION INFORMATION AIKEN REGIONAL MEDICAL CENTER 302 UNIVERSITY PKWY AIKEN SC 29801		30. BALANCE DUE \$ 2040 00	
31. BILLING PROVIDER INFO & PH. # (803) 649-6366		32. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) MARGO J HEIN MUNIZ MD	
33. DATE OF SERVICE 3/19/2010		34. DATE OF BILLING 3/19/2010	

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION